Aviva ReachOut Referral Form

Referrer Details

Date: _____

Name of Referrer: _____ Phone: _____

Organisation: _____

How referral received: Email ☐ Support Line ☐ Walk-in ☐ Self-referral ☐

Post ☐ Other (please explain) ☐ _____

Client Details

Client Name: _____

Date of Birth: _____ Ethnicity: _____

Current Address: _____

_____

Phone Number: _____ Work: _____

Can we leave a message? (Y / N) Can we leave a message? (Y / N)

Client's Family Details

Partner or Ex-partner's name: _____

Date of Birth: _____ Ethnicity: _____

Please list the names and ages of all children under the age of 18, including step-children or other children in the client's care.

NAME	DOB	AGE	ETHNICITY	RELATIONSHIP TO CLIENT

Current risks and reason for the referral

_____

_____

_____

Alcohol / Drug use **Yes** ☐ **No** ☐

_____

_____

Has the client been assessed for alcohol or drug use? (Y / N)

Do you feel that the client has AOD issues that would impact on their ability to engage with ReachOut's services? (Y / N)

If yes, please give details:

_____

_____

Gambling **Yes** ☐ **No** ☐

Does the client have a history of problem gambling? (Y / N)

Has the client received any support in relation to the gambling problem? (Y / N)?

Criminal History (Violence Related Charges): **Yes** ☐ **No** ☐

If yes, please give details:

_____

_____

Is the client subject to a current Protection Order, Bail conditions, Probation conditions or Parenting Orders?

Yes ☐ **No** ☐

If yes, please give details:

_____

_____

Mental Health Wellbeing

Are you aware of any Mental Health risks that may impact on ReachOut staff delivering their services?

Yes ☐ **No** ☐

If yes, please give details

_____

_____

_____

Referrer's signature: _____ Date: _____

Please return to: referral@avivafamilies.org.nz; Aviva ReachOut, P.O. Box 24161 Christchurch 8141